

# FOCUS

*Communicating NCID's prevention and control programs for new and reemerging infectious diseases*

## Message from the Director

Dear Colleagues:

The period since our last *Focus* has been eventful. In August, the bombing of the U.S. Embassy in Nairobi, Kenya, killed or injured several colleagues (see facing article). This tragedy was a sobering reminder that terrorism is a global threat.

In September, Dr. Jonathan Mann (EIS '75, former director of WHO's AIDS Program and founder of NCID's Project SIDA in Zaire in 1986) and his wife, Dr. Mary Lou Clements-Mann (a vaccinologist who served on the ACIP) died in the crash of Swiss-Air Flight 111.

Each of these deaths marked losses, not just for their friends, families, and the public health community, but for the world at large, which they all served so generously.

Also since our last issue, CDC's plan, *Preventing Emerging Infectious Disease Threats: A Strategy for the 21st Century*, has been published. Much hard work by CDC colleagues and collaborators, under the capable leadership of Dr. Sue Binder, made this possible.

I am very pleased to announce that Dr. Joseph McDade, former associate director for laboratory science, NCID, has accepted the position of deputy director of the center. We look forward to working with all of you in implementing the CDC emerging infections plan and addressing other important NCID priorities.

*James M. Hughes*  
James M. Hughes, M.D.

## Focus on Global Health

### CDC suffers painful losses in Nairobi embassy bombing

**A**t about 10:30 a.m. on Friday, August 7, 1998, in Nairobi, Kenya, a car bomb exploded in the parking lot of the U.S. Embassy, which is located on one of the busiest street corners in downtown Nairobi. This senseless terrorist act took the life of Louise Martin, EIS Class of '85, wife of Doug Klauke of the National Immunization Program, who is stationed in Nairobi as part of his detail to the World Health Organization's polio eradication program. Louise had become coordinator of the Malarone Donation Program to combat childhood malaria, working for the Task Force for Child Survival and Development. In addition to the tragic death of Dr. Martin, CDC suffered other direct losses from the bombings.

For almost 20 years, NCID's Division of Parasitic Diseases (DPD) has had a field station in Kenya, CDC/KEMRI (Kenya Medical Research Institute). The field station has two locations—an office and laboratories on the main KEMRI campus in Nairobi, and offices, laboratories, and field sites on another KEMRI campus in Kisian, in western Kenya. The primary focus of the work at CDC/KEMRI has been on malaria, but, more recently, it has also involved collaborative studies on HIV/AIDS, schistosomiasis, diarrheal diseases, and other public health problems.

Three DPD employees are stationed in Kenya: Bernard Nahlen (medical epidemiologist and director) and Christi

Murray (public health advisor), who live in Kisumu, and Bill Hawley (medical entomologist), who lives in Nairobi with his wife Carol and sons Allen and Billy. Carol Hawley works in the APO (post office) of the U.S. Embassy. On the morning of August 7, Carol was at her job, and Pauline Abdullah (who has been the administrative assistant at the CDC/KEMRI office in Nairobi for 10



PHOTO: Dan Colley

*Despite the shock of the bombing, CDC's field projects continued with minimal disruption, thanks to the dedication of the Kenyan staff.*

years) and Josiah Owuor (the office's driver in Nairobi) were at the Embassy picking up mail for CDC/KEMRI, as they did every day. At 10:30 a.m., Pauline and Carol were coming from the APO with the mail and Josiah was waiting for them by the car in the parking lot. The bomb killed Josiah and severely injured both Carol and Pauline.

By Sunday, Carol and Pauline had been evacuated to Lanstruhl Regional Medical Center in Germany. After evaluation in Germany, Carol was taken to Brooke Army Medical Center near San Antonio, Texas. She under-

*continued on page 2*

went surgery there. In late August, she was transferred to the Shepherd Center in Atlanta, where she underwent extensive rehabilitation. She returned to Kenya in early October.

Pauline underwent surgery several times and is healing well. She returned to Nairobi in early September to continue rehabilitation there.

Bill Hawley and Carol's sister accompanied Carol in her medical evacuations, and Allen and Billy joined them in Atlanta. Pauline's cousin Jessica (a Kenyan physician) accompanied Pauline to Germany. Josiah's wife, two small children, and mother received counseling, as did the many other families bereaved by this tragedy. Pauline's sister, Lucy Onono, who worked in the Embassy, was also killed; she is survived by her husband and five children.

This was a very difficult time for NCID staff in Atlanta as well—waiting, watching, feeling helpless, and praying—while friends and colleagues faced such horrendous situations. The courage shown both by those who were injured and by those who have provided support throughout the restoring process has been extraordinary. (Superb support was provided by the Department of State and the U.S. Army medical units in Germany and Texas.)

We in Atlanta hope that the Kenyan staff know how much we appreciate their efforts to bring CDC's mission to the world and that we support their leadership in global health.

A relief fund has been set up for the families of those devastated by the bombing. To contribute, send a check made out to Altaf Lal, c/o Bjork Hardardottir of DPD's Immunology Branch, MS F-12. ■

Dan Colley  
Director, Division of Parasitic Diseases

## Focus on Hospital Infections

### Blood tubing identified as cause of dialysis outbreak that affects 30 patients

**H**ospital Infections Program (HIP) staff collaborated in an investigation that identified improperly manufactured tubing as the cause of an outbreak of hemolysis (premature breakdown of red blood cells) that affected 30 hemodialysis patients in three states during May 1998. Two patients died.

HIP staff, led by Rosemary Duffy, collaborated with the Food and Drug Administration (FDA), a dialysis center in Nebraska, and other federal and state groups to control the multistate outbreak, which occurred in Nebraska, Maryland, and Massachusetts.

HIP centered its investigation in Nebraska and FDA took the lead in Maryland. The Massachusetts outbreak was handled locally.

The investigation was prompted by a cluster of cases in each of the three states during which patients experienced chest pain, shortness of breath, nausea, or abdominal pain while undergoing hemodialysis.

"All of these symptoms are characteristic of hemolysis," said Dr. Duffy. "And when the serum appears pink, which it did with our patients, you have another strong suggestion of hemolysis. Basically, the serum, which normally appears yellow or clear, appears pink because the red blood cells are breaking down."

During collaboration between the two teams in Nebraska and Maryland, investigators discovered that patients in both locations were using blood

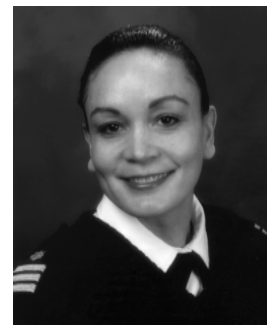
tubing from the same manufacturer and, more importantly, from the same lot of tubing. In the dialysis process, the patient's blood flows through tubing into dialysis machines that cleanse the blood and then returns through tubing and back into the patient.

"The same manufacturer wouldn't be unusual," said Dr. Duffy. "But tubing from the same lot was suspicious, and that led us to examine the tubing much more closely than we normally would have."

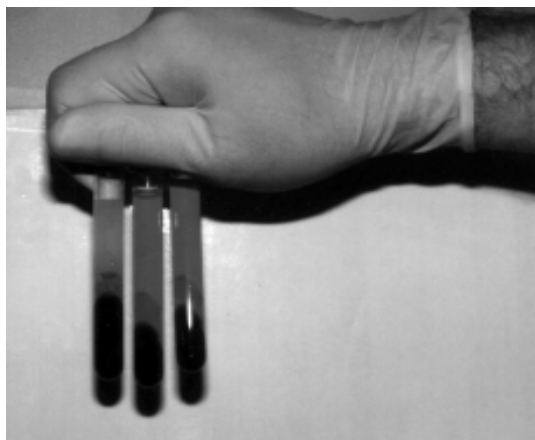
The examination revealed that an opening in the tubing through which blood was pumped during dialysis was narrower than it should have been. The pressure placed on the blood as it was being "forced" through the opening caused the red blood cells to break down.

"When the red cells break down, they can't carry oxygen," said Dr. Duffy. "That's why the patients experienced shortness of breath."

The narrow opening in the tubing resulted from a misalignment during the manufacturing process that prevented a device that creates the opening from penetrating to the proper depth. As a result of the investigation, the manufacturer voluntarily recalled the implicated lot of tubing. ■



Rosemary Duffy



Serum separator tubes are used to test for hemolysis.

## Focus on Bacterial and Mycotic Diseases

## Foodborne lab celebrates 50th anniversary

A party with a birthday cake marked the 50th anniversary of the opening of CDC's Enterics Laboratory (now the Foodborne and Diarrheal Diseases Laboratory), which opened on July 1, 1948, evoking memories of people, challenges, and achievements in the past 5 decades. Visitors George Herman and Eugene Gangarosa, who recalled early days of the laboratory's history, and Agnes Ewing, wife of the late William H. Ewing, former chief of the Enterics Unit, joined current and former laboratory staff members in reviewing photos and other memorabilia.

The Enterics Laboratory opened under the direction of Joseph Mountin, the "founding father" of CDC, at a time when the Communicable Disease Center's work on malaria was progressing and the need arose for a reference laboratory for other diseases, especially typhoid fever. According to William Martin, director, Scientific Resources Program, many of the pathogens identified in the laboratory in the 1960s and 1970s are still familiar: *Salmonella*, *Shigella*, *Vibrio cholerae*, and *Escherichia coli*, which was known then as a cause of enteric illness in



The birthday cake celebrating "50 great years" of the Foodborne and Diarrheal Diseases Laboratory's history.

infants. Many of these were strongly suspected to be transmitted by food that was improperly cooked or handled, but the association was not confirmed. The role that antibiotics added to animal feed played in the spread of these organisms was also discussed as early as the 1960s; today, with the increase in antimicrobial-resistant organisms, this issue has become even more pertinent.

Because of the interests and expertise of its leaders, the laboratory gained a reputation in the area of taxonomy. In 1955, Philip Edwards and William Ewing published the first edition of *Identification of Enterobacteriaceae*, a manual on biochemical identification and serotyping of this family of bacteria. Also referred to as "The Red Book," the manual has had four editions and is used and relied on worldwide. The laboratory, in addition to being a reference resource for enteric bacterial pathogens from states and several countries, also became an important training center for visitors from around the world and state laboratorians.

The laboratory was first located in Chamblee, moving to the Clifton Road campus when it opened in 1960. Through the years, CDC reorganizations and emerging diseases have shifted some its emphases, locating it in the Center for Infectious Diseases and increasing the epidemiologic focus in 1981. Many CDC current and

former staff members have continued and built on the laboratory's tradition of expertise and seen it through changes more dramatic than would have been imagined in the early years. According to some longer term personnel—Bill Martin, Don Brenner, Jim Farmer, Joy Wells, Frances Brenner—the advent of molecular techniques, the electronic transfer of information, and the emergence of newly recognized diarrheal pathogens have all strongly influenced the work of the laboratory. Questions about causes of outbreaks and the nature of pathogens that could only be speculated on in the past can now be answered quickly and accurately.

What does the future look like? Current laboratory director Bala Swaminathan believes that "as new technologies continue to improve our ability to detect and identify causes of foodborne disease, we will almost certainly recognize new pathogens and new roles for old pathogens. For the old 'enterics' lab, the next 50 years should be as exciting as the first 50." ■



Joe McDade (left) and Jim Farmer examine pictures from previous decades of the Foodborne and Diarrheal Diseases Laboratory's history.

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## Focus on Quarantine

## DQ hosts first GeoSentinel meeting

**G**eoSentinel, a sentinel network of travel medicine providers, was established in May 1996 by the Division of Quarantine (DQ) and the International Society of Travel Medicine (ISTM). During June 11-12, the site representatives, from the United States (Alabama, California, Florida, Hawaii, Maryland, Massachusetts, New York, Texas, and Washington State), Australia, Canada, Israel, Nepal, New Zealand, and Switzerland, met in Atlanta, in many cases for the first time face to face.

The objectives of the GeoSentinel program are the following:

- Develop an international surveillance network of travel medicine clinics
- Track geographic and temporal trends in infectious diseases among international travelers
- Identify emerging infectious diseases among international travelers and participate in CDC's effort to establish surveillance for emerging and reemerging infections.
- Disseminate information about emerging infections to the network of GeoSentinel providers and the larger network of ISTM providers

Participating travel medicine clinics complete a questionnaire form for each eligible patient. The forms are faxed to DQ headquarters, where the data are entered into the Geo-Sentinel data base and analyzed. Quarterly reports are generated that provide feedback to the sites about trends in diagnoses, both at their own clinic and in the network overall. The supervisor of the GeoSentinel project in DQ is Martin Cetron; Indira Srinivasan is the data manager, and Leisa Weld performs the statistical analysis.



*Participants in the annual meeting of GeoSentinel site directors, held at CDC in June 1998. Front row (L-R): Carolyn Petersen, San Francisco, CA; Maggie Phillips, Adelaide, Australia; Denise Hicks, San Antonio, TX; Phyllis Kozarsky, Atlanta, GA; Indira Srinivasan and Martin Cetron, DQ. Second row (L-R): Susan Stokes, OD, NCID; Leisa Weld, DQ; Vernon Ansdell, Honolulu, HI; Eli Schwartz, Israel; Jay Keystone, Toronto, Ontario, Canada; Russell McMullen, Seattle, WA. Third row (L-R): Bradley Sack, Baltimore, MD; Suzanne Zane, EIS Officer, DQ; Bradley Connor, New York, NY; David Freedman, Birmingham, AL; Alejandra Gurtman, New York, NY. Back row (L-R): Brant Williams, Boston, MA; Patrick Bovier, Geneva, Switzerland; Thomas Nutman, Bethesda, MD; Megan Williams, Auckland, New Zealand; Brenda Bagwell, DQ; Carmelo Licitra, Orlando, FL.*

In the 2 years since its inception, the scope of the GeoSentinel project has widened. From an initial focus limited to diagnoses of schistosomiasis, dengue, hepatitis, and fever of unknown origin, all diagnoses seen in patients who become ill after travel are now included in the eligibility criteria. The data collection instrument has been streamlined to a single-page format that can readily be faxed to headquarters. The surveillance protocol has been revised to include a new manual, case definitions, and diagnostic codes.

The network has been expanded to include 23 sites, with 16 domestic and seven international clinics participating as of June 1998. The first "destination" clinical site, Kathmandu, Nepal, was added in November 1997. Staff there will send data to Atlanta via an electronic data-entry system, rather than by fax.

The meeting provided an opportunity to compare notes on procedures used in collecting GeoSentinel data. Considerable time was spent ensuring that complex cases are interpreted and reported consistently. Many suggestions were made about ways to refine the data collection, such as translation of forms into Spanish, French, and German. The data collected and analyzed so far were presented.

As a result of the meeting, the comparability of data will be improved, and sites will be better able to use the data for their own research. The most recent quarterly reports, which were mailed in October, show that data are now sufficient to allow estimation of baseline rates in this population for schistosomiasis, hepatitis, filariasis, fever of unknown origin, diarrheal disease, and malaria. ■

## Focus on AIDS, STD, and TB Laboratory Research

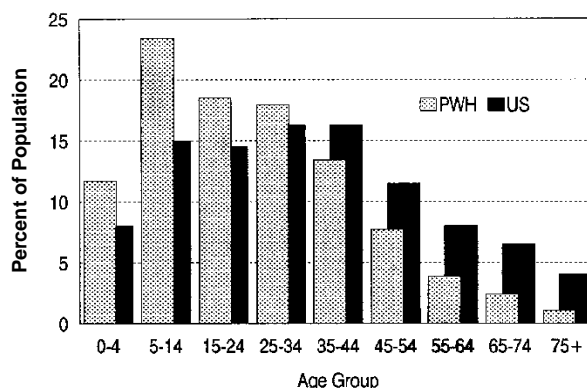
## Hemophilia in the United States: data from the first population-based study

**T**he Hematologic Diseases Branch (HDB), Division of AIDS, STD, and TB Laboratory Research (DASTLR), has published a report on data obtained from the first population-based study of hemophilia in the United States.

The report contains data from the Hemophilia Surveillance System (HSS), a collaborative project begun in 1993–1994 with health departments in six states—Colorado, Georgia, Louisiana, Massachusetts, New York, and Oklahoma. Michael Soucie, an epidemiologist in HDB, is the project officer for the study.

During 1993–1995, HHS identified 3,058 males with hemophilia in these six states. Most cases (72%) occurred among white males, although prevalence rates per 100,000 population were similar among white (13.4), African-American (12.3), and Hispanic (11.4) males. This prevalence is similar to that reported in other countries with active surveillance for hemophilia. Application of age-specific prevalence rates from these six states to the U.S. population has resulted in an estimated national population of 13,670 cases of hemophilia A and 3,660 cases of hemophilia B. For the 10-year period 1982–1991, the average incidence of hemophilia A and B in the six HSS states was estimated to be approximately 1 in 5,000 live male births, based on patients alive in 1994.

The median age of 22.7 years for persons with hemophilia identified during this period was 10 years less than that of U.S. males overall, likely reflecting the impact of HIV infection/AIDS on this population (Figure). Of the 236 deaths reported among persons with hemophilia in these states during 1993–1995, HIV-related disease was the primary or underlying cause of death in 65%.



Age distribution of persons with hemophilia (PWH) compared with the U.S. male population.

Other factors related to increased risk of death were increasing age and clinical hepatitis. However, mortality risk was lower among persons who received treatment at a hemophilia treatment center at least once during the study period.

Through HSS, cases are identified by using a wide variety of resources available to the health departments of the surveillance states. Approaches include contacting physicians and hematologists, clinical laboratories, hemophilia treatment centers, factor-concentrate suppliers, pharmacies, and other potential providers of care or supplies for this population. In some states, data bases such as hospital-discharge records and Medicare claims data are reviewed. Once cases are identified, trained data abstractors collect medical records data using standardized data collection forms. In addition to collecting information on the incidence and prevalence of hemophilia, the surveillance system is designed to obtain information on death rates, predictors of mortality, the occurrence of complications, and the use of health-care resources in this population.

The first issue of the report is available from HANDI, the information service of the National Hemophilia Foundation (1-800-42-HANDI), or it can be accessed at the HDB web site: [www.cdc.gov/ncidod/dastlr/hematology.htm](http://www.cdc.gov/ncidod/dastlr/hematology.htm). ■

## IDEA Place

## Prevention of hepatitis and enteric diseases in gay and bisexual men in Massachusetts

Hepatitis A has increased fourfold among adult men in Massachusetts. In Greater Boston, amebiasis, giardiasis, and cryptosporidiosis have increased threefold in this population. Many of these cases are due to male-to-male sexual transmission. To assess the serologic status and risk behaviors of males who have sex with males (MSM), the Massachusetts State Health Department has begun a pilot project in Greater Boston and Provincetown. The project also provides hepatitis A vaccine to these clients.

Participants provide a blood sample (anonymously), which is tested for past infection with hepatitis C and for past infection or vaccination against hepatitis A and B. The researchers also collect information on the participants' attitudes, beliefs, and behaviors relating to HIV, hepatitis A, B, and C, and enteric diseases. In addition, the project provides MSMs with specific information on how to reduce the risk of enteric diseases. The success of this pilot project, has led the state health department and key community agency partners who work with gay/bisexual males to expand the availability of vaccines for hepatitis A and B. The findings have led to recommendations that new, effective messages on how to reduce the risk of hepatitis, HIV, and enteric diseases must be developed for this community.

For more information, contact Tim Broadbent or Mary Sheryl Horine at 617-983-6800 or by E-mail: [timoth.broadbent@state.ma.us](mailto:timoth.broadbent@state.ma.us). ■

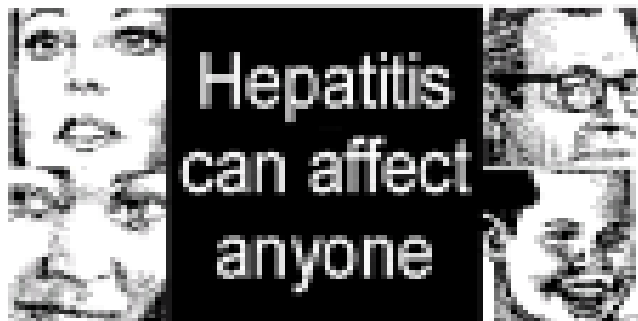
## Focus on Viral and Rickettsial Diseases

## CDC publishes new prevention guidelines for hepatitis C virus infection

**R**ecommendations for the identification, counseling, testing, and medical referral of persons at risk for hepatitis C virus (HCV) infection were published by CDC on October 16 (MMWR 47[RR-19]: 1-54).

"The science-based recommendations contained in this document will serve as the basis for moving forward with a national plan to control and prevent HCV infection and HCV-associated chronic liver disease in the United States," according to Harold Margolis, chief of the Hepatitis Branch, Division of Viral and Rickettsial Diseases.

The new recommendations are an important element of a larger public health effort directed at hepatitis C prevention and control. Earlier this year, HHS Secretary Donna Shalala announced a program to carry out recommendations of the HHS Advisory Committee on Blood Safety and Availability with regard to hepatitis C prevention. These measures include identifying and notifying persons who received a blood transfusion from a donor who later tested positive for HCV infection. The secretary's announcement also called for implementing a public education campaign directed at all people who are at risk for hepatitis C, evaluating initial prevention efforts, and identifying ways to address unmet needs.



Information about hepatitis C is available on the Hepatitis Branch's web site (<http://www.cdc.gov/ncidod/diseases/hepatitis>) or toll-free information line (1-888-4HEPCDC).

### About Hepatitis C

Hepatitis C is an emerging infectious disease that has become an increasingly important public health concern during the last several years. The disease is caused by infection with hepatitis C virus (HCV), which was discovered in 1988. HCV infection is a leading cause of cirrhosis in the United States and of liver cancer worldwide. Almost 4 million Americans are infected with HCV, and many of these persons may not be aware of their infection. No vaccine is available for hepatitis C, but some patients may benefit from treatment with interferon or interferon-ribavirin combination therapy.

HCV infection is spread primarily by direct contact with blood. Currently, injecting drug use is the most common type of exposure, accounting for approximately 60% of recent cases. An additional 20% of cases are associated with high-risk sexual practices, and another 10% are related to various known exposures, including occupational, hemodialysis, household, and perinatal exposures.

Some persons, may be at risk for HCV infection and should be routinely tested. These include

- 1) persons who ever injected illicit drugs (even those who experimented a few times many years ago);
- 2) persons who received clotting factor concentrates produced before 1987;
- 3) persons who were notified that they received blood from a donor who later tested positive for hepatitis C;
- 4) persons who received a transfusion of blood or blood components before July 1992;
- 5) persons who received an organ transplant before July 1992;
- 6) persons who have ever had long-term hemodialysis therapy;
- 7) persons with evidence of liver disease;
- 8) health care and public safety workers after exposure to HCV-positive blood; and
- 9) children born to HCV-positive women.

In addition to preparing the HCV prevention recommendations, staff of the Hepatitis Branch have worked intensively on numerous other related HCV prevention activities during the past year.

These efforts have included

sponsorship of a national videoconference on hepatitis C diagnosis, management, and prevention; expanded research on HCV transmission; improved coordination with other federal agencies and with nongovernment organizations interested in the diagnosis,

prevention, and medical management of viral hepatitis; increased disease surveillance; and development and dissemination of health education materials, including hepatitis C prevention audiotapes, pamphlets, resource lists, and other information. ■



## NEWS BRIEFS



### PulseNet connects laboratories

On May 22, 1998, at a White House event attended by Vice President Al Gore, HHS Secretary Donna E. Shalala announced the launching of PulseNet, a national network of public health laboratories that perform DNA "fingerprinting" on bacteria that may be foodborne. The "fingerprint" patterns can be sent electronically and compared quickly through an electronic database at CDC. They are generated by pulsed-field gel electrophoresis (PFGE), which can distinguish strains of an organism such as *Escherichia coli* at the DNA level. Similar PFGE patterns suggest that two different *E. coli* isolates—such as one from a patient and one from food—come from a common source, and identifying these connections can help determine the cause of an outbreak. Finding similar patterns can also help scientists determine whether an outbreak is occurring, even if the affected persons are geographically far apart. Through PulseNet, outbreaks and their causes can be identified in a matter of hours rather than days, as was done previously. Control measures can be initiated and outbreaks stopped.

CDC began setting up PulseNet in 1995 with state health laboratories in Massachusetts, Minnesota, Texas, and Washing-

ton. Since then, several other states and federal agencies have come on line. In the future more participants are expected, as well as databases for other foodborne pathogens.

### *H. pylori* campaign wins accolades

CDC's "Happy Ulcer Sufferers" campaign—designed to tell the world the good news that ulcers caused by infection with *Helicobacter pylori* can be cured—recently received two communications industry awards. The campaign was awarded the 1988 Crystal Communicator Award of Excellence as well as a certificate of commendation for a television public service announcement in the Public Relations Society of America's Bronze Anvil Award competition.

CDC's *H. pylori* toll-free number is 1-888-MY-ULCER. The web site address is: <http://www.cdc.gov/ncidod/dbmd/hpylori.htm>

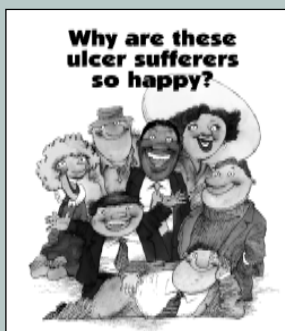
### Hepatitis C videoconference award presented

A special CDC/ATSDR group honor award for communication services was recently presented to members of the Hepatitis Branch, DVRD, for

their work in conducting a live, interactive videoconference, "Hepatitis C: Diagnosis, Clinical Management, and Prevention" last year. The course, designed for health-care providers, was broadcast to approximately 600 sites throughout the United States and Puerto Rico. The award was presented to Miriam Alter, Louise Barden, Steven Bice, Willie Bower, Susan Goldstein, Wesley Hodgson, Rob Lyerla, Harold Margolis, Eric Mast, Linda Moyer, and Ian Williams.

### Roger Glass receives Pasteur Award

Roger Glass, chief, Viral Gastroenteritis Section, Respiratory and Enteric Viruses Branch, DVRD, was a corecipient of the CVI Pasteur Award for Recent Contributions to Vaccine Development presented in Geneva on November 10. Dr. Glass was given the award in honor of his work on a vaccine for rotavirus, a leading cause of severe diarrhea in children. The other award recipients were Al Kapikian (who developed the tetravalent rotavirus vaccine) and Ruth Bishop (who discovered the virus). According to DVRD Director Brian Mahy, "This award recognizes the magnificent efforts of Dr. Glass and his colleagues to address this important emerging infectious disease."



## News Makers

### Staff Changes

**Julie Bettinger** has joined NCID as an ASPH fellow in DPD, working with David Addiss. She just completed her M.P.H. degree at Johns Hopkins University.

**Ulana Bodnar** has joined DQ's Surveillance and Epidemiology Branch. She just completed her EIS term in the Wisconsin State Health Department.

**Denise Cardo** has been selected as chief of the HIV Infections Branch, HIP. Dr. Cardo joined HIP in 1993 and previously worked in infectious diseases and hospital epidemiology at Escola Paulista de Medicina, Sao Paulo, Brazil.

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**Paul Gangarosa** is the new data manager for DQ's Surveillance and Epidemiology Branch.

**Judith Graber** is an epidemiologist, who will be working with the Data Management Branch, DQ.

**Sanjay Mathur** joins NCID as a new ASPH fellow. He will be working with Larry Barat in DPD and Stefanie Steele in DQ on a travelers' health project. He spent the last several months working with a community-based organization in El Paso, Texas.

**Bobbie Person** joins NCID's OHC to work on emerging infectious disease prevention, specifically disseminating and promoting the second EID plan. She is a behavioral scientist who worked for many years in the AIDS Program at CDC.

**Stefanie Steele** is the new health communicator in the Travelers' Health Section, DQ.



**Todd Weber** (EIS '90) is joining NCID in November as a senior medical officer coordinating CDC's efforts to address the challenges of antimicrobial resistance. Todd has served as a medical epidemiologist in the divisions of STD Prevention and HIV/AIDS Prevention. From January-June 1998, he was CDC's representative to the White House Office of National AIDS Policy.

## Retirements

**Roger L. Anderson**, chief of the Environmental Laboratory Section, Hospital Environment Laboratory Branch, HIP, retired from CDC on September 28 after 33 years of service.

**Joel Hardee**, laboratory technician, Technical Services Branch, SRP, retired on September 18 after 23 years of service.

**Franklin R. Miller**, deputy director of SRP, retired from CDC on July 28 after 34 years of service.

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**Richard Moyer**, chief of the Medical Screening and Health Assessment Branch of DQ, retired on October 3 after more than 35 years of service.

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